



**Klamath Orthopedic and Sports Medicine Clinic**  
**MEDICAL HISTORY**  
**New patient or yearly update**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Social history:**

Do you now or have you ever used tobacco? NO YES (please complete below)

Type of tobacco (cigarettes, chew, etc.) \_\_\_\_\_

Packs/cans per day: \_\_\_\_\_

How long have you used tobacco: \_\_\_\_\_

Quit: \_\_\_\_\_ years ago.

Do you drink alcohol? NO YES (please complete below)

Type of alcohol (beer, wine, hard, etc.) \_\_\_\_\_

How often? \_\_\_\_\_

Do you use recreational drugs? NO YES (please complete below)

Type of drug (marijuana, cocaine, heroin, etc.) \_\_\_\_\_

How often? \_\_\_\_\_

**Medications**

List medications you are currently taking including vitamins and medical marijuana:

Medication name	Strength	Dosage	Reason

**Allergies**

Drug allergies (hives, rashes, vomiting or unable to breathe): Which medications can you NOT take?

Medication	Reaction	Medication	Reaction

Name \_\_\_\_\_ Date \_\_\_\_\_

### Past medical history

Please check the appropriate box if you, or anyone in your family, have had any of these medical problems. If you mark yes for the family member, please write which family member next to the medical problem. Example: mother, father, grandmother, etc.

<u>You</u>	<u>Family/Who</u>	<u>You</u>	<u>Family/Who</u>	<u>You</u>	<u>Family/Who</u>
<input type="checkbox"/>	<input type="checkbox"/> AIDS/HIV _____	<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse _____	<input type="checkbox"/>	<input type="checkbox"/> Parkinson's _____
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/>	<input type="checkbox"/> Blood Clots _____	<input type="checkbox"/>	<input type="checkbox"/> Ulcers _____
<input type="checkbox"/>	<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia _____	<input type="checkbox"/>	<input type="checkbox"/> Peripheral Vascular Disease _
<input type="checkbox"/>	<input type="checkbox"/> Anemia _____	<input type="checkbox"/>	<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/>	<input type="checkbox"/> Renal Disease _____
<input type="checkbox"/>	<input type="checkbox"/> Angina _____	<input type="checkbox"/>	<input type="checkbox"/> Reflux (GERD) _____	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis __
<input type="checkbox"/>	<input type="checkbox"/> Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/> Gout _____	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis _____
<input type="checkbox"/>	<input type="checkbox"/> Asthma _____	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/> Seizures _____
<input type="checkbox"/>	<input type="checkbox"/> Atrial Fibrillation _____	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea _____
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/> Lupus _____	<input type="checkbox"/>	<input type="checkbox"/> Keloid Scars _____
<input type="checkbox"/>	<input type="checkbox"/> Cancer _____	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/> Spinal Stenosis _____
<input type="checkbox"/>	<input type="checkbox"/> Stroke _____	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease _____	<input type="checkbox"/>	<input type="checkbox"/> MRSA _____
<input type="checkbox"/>	<input type="checkbox"/> Depression _____	<input type="checkbox"/>	<input type="checkbox"/> Lyme Disease _____	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/>	<input type="checkbox"/> COPD _____	<input type="checkbox"/>	<input type="checkbox"/> Migraines _____	<input type="checkbox"/>	<input type="checkbox"/> Heart Valve Disease __
<input type="checkbox"/>	<input type="checkbox"/> Coronary Artery Disease _____	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis _____	<input type="checkbox"/>	<input type="checkbox"/> Neuropathy _____
<input type="checkbox"/>	<input type="checkbox"/> Crohn's Disease _____	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack _____	<input type="checkbox"/>	<input type="checkbox"/> Obesity _____
<input type="checkbox"/>	<input type="checkbox"/> Degenerative Joint Disease __	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> Chronic Pain Syndrome
<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis _____	<input type="checkbox"/>	<input type="checkbox"/> Malignant Hyperthermia _____		
<input type="checkbox"/>	<input type="checkbox"/> Congestive Heart Failure _____	<input type="checkbox"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II _____		
<input type="checkbox"/>	<input type="checkbox"/> Other _____				
<input type="checkbox"/>	<input type="checkbox"/> Chronic Neck Pain _____	<input type="checkbox"/>	<input type="checkbox"/> Chronic Back Pain _____		

I am adopted and don't know my family history

### Past surgical history

Please indicate if you have had any of the following surgeries

Year	Year
<input type="checkbox"/> Heart Bypass(CABG) _____	<input type="checkbox"/> Hip Replacement _____
<input type="checkbox"/> Heart Valve _____	<input type="checkbox"/> Other Hip Surgery _____
<input type="checkbox"/> Cancer Surgery _____	<input type="checkbox"/> Knee Replacement _____
<input type="checkbox"/> Prostate Surgery _____	<input type="checkbox"/> Knee Arthroscopy _____
<input type="checkbox"/> Spine Surgery _____	<input type="checkbox"/> Other Knee Surgery _____
	<input type="checkbox"/> Shoulder Replacement _____
	<input type="checkbox"/> Shoulder Arthroscopy _____
	<input type="checkbox"/> Other Shoulder Surgery _____
	<input type="checkbox"/> Other Surgery _____

## Implant history

Indicate if you have any of the following implants and the year it was implanted. If you were provided a manufacture information card please provide a copy for your chart.

- Orthopedic implants (joint implants, plates, screws, etc) \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Heart stent \_\_\_\_\_
- Defibrillator \_\_\_\_\_
- Aneurysm clip \_\_\_\_\_
- Neurostimulators \_\_\_\_\_
- Penile implants \_\_\_\_\_
- Mesh implants \_\_\_\_\_
- Implanted hearing aids \_\_\_\_\_
- Eye implants \_\_\_\_\_
- IUD \_\_\_\_\_
- Other \_\_\_\_\_